STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155166	A. BUILDING _____ B. WING _____	03/15/2011

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F0000	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00087434. Complaint IN00087434 - Substantiated. Federal/State deficiencies related to the allegations are cited at F225, F226, and F282. Survey dates: March 7, 8, 9, 10, 11, and 15, 2011 Facility number: 000083 Provider number: 155166 AIM number: 100289670 Survey team: Regina Sanders, RN,TC Marcia Mital, RN Sheila Sizemore, RN Kelly Sizemore, RN Census bed type: SNF/NF: 146 Total: 146 Census payor type: Medicare: 17 Medicaid: 121 Other: 8 Total: 146	F0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a post survey revisit on or after April 15, 2011.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Sample: 24 Supplemental sample: 20 These deficiencies also reflect state findings in accordance with 410 IAC 16.2. Quality review 3/17/11 by Suzanne Williams, RN			

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F0176 SS=D	Based on observation, record review, and interview, the facility failed to ensure a resident had been assessed and determined to be safe to administer her own medication related to, medications left at the bedside and an order to keep eye drops at the bedside, for 1 of 24 residents reviewed for medications in a sample of 24. (Resident #82) Findings include: During the initial tour on 3/7/11 at 9:45 a.m., with LPN #6, Resident #82 was observed sitting up in her rocker. The table beside the resident had two hand held inhalers laying on top of the table. The first inhaler was Spiriva and the second was Advair 250/50. Resident #82 indicated she had already administered the inhalers and respiratory would pick them up later. Resident #82's record was reviewed on 03/08/11 at 3:25 p.m. The resident's diagnoses included, but were not limited to, glaucoma and chronic obstructive pulmonary disease. The Resident's Physician's Recapitulation Orders, dated 03/11, indicated an order for Spiriva Handihaler (breathing medication), inhale one puff daily, Advair Diskus (breathing medication), inhale one puff twice daily, and Xalatan (eye drops) 0.005%, instill one drop in both eyes at	F0176	F176 RESIDENT SELF-ADMINISTER DRUGS IF NEEDED SAFE An individual resident may self-administer drug if the interdisciplinary team has determined that this practice is safe. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** · There is no corrective action for resident #82 since the alleged deficiency was in the past. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** · All residents have the potential to be affected by the alleged deficient practice. · Licensed nurses and respiratory staff will be educated by the Director of Nursing Services/designee on the proper procedures required prior to self-administration of medication by 4/15/11. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur** During daily rounds Customer Care Representatives,	04/15/2011

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	bedtime, may keep at bedside. The Resident's record lacked documentation to indicate the resident had been assessed for safe self-administration of medication. There was a lack of documentation on the Resident's Physician's Recapitulation orders, dated 03/11, to indicate the resident had an order to self-administer the Spiriva and Advair inhalers. During an interview on 03/09/11 at 2:15 p.m., the Director of Nursing indicated the resident did not have an assessment to self-administer her medications. 3.1-11(a)		nurses and Unit · Managers will assess the environment for medications that may have been left at the bedside. · All residents who self-administer medications will have an assessment completed to ensure safety and their capability of self-medication administration. · Nursing Round sheets will be reviewed daily by the DNS/designee for any discrepancies. · Noncompliance with facility policy and procedure may result in employee re-education and/or disciplinary action up to and including termination. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** · A “Self-Administration of Medication” CQI tool will be utilized weekly x 4, then monthly thereafter. · Data will be submitted to the CQI Committee for review and follow up. · Action plans will be developed as needed for issues identified to improve compliance.	

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F0221 SS=D	Based on observation, record review, and interview, the facility failed to ensure a resident was not physically restrained without the appropriate diagnosis, without any attempts at reduction, and applied per family request, for 1 of 1 resident with physical restraints in a sample of 24. (Resident #89). Findings include: 1. During the initial tour on 3/7/11 at 9:45 a.m., the West Unit Manager indicated Resident #89 had a self release belt alarming belt which was a physical restraint. Resident #89's record was reviewed on 3/8/11 at 9:23 a.m. Resident #89's diagnoses included, but were not limited	F0221	**F221 RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS** The resident has the right to be free from any physical restraints imposed for purpose of discipline or convenience, and not required to treat the resident's medical symptoms. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** · There is no corrective action for resident #89 since the alleged deficiency was in the past. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** · All residents with restraints have the potential to be affected by the alleged deficient practice. All staff will be educated by the Director of Nursing Services/designee · on residents right to be free from the use of physical restraints by 4/15/11. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur**	04/15/2011

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	to, Alzheimer's Disease, arthritis, and stroke. Resident #89's Physician's Order Recapitulation, dated 3/11, indicated orders, dated 8/13/10, for the self releasing velcro seat belt with alarm when up in wheelchair and release belt every two hours to observe skin for any redness or irritation. A care plan, dated 9/3/10, indicated "(Resident #89's name) uses self releasing velcro belt with alarm while up in wheelchair. Goals: Resident will be safe with the least restrictive device as possible...Interventions...Releas e belt and reposition every 2 hours...Interdisciplinary team to review every 30 days and as needed for least restrictive		· Residents with physical restraints were re-assessed by the Interdisciplinary Team to ensure compliance with the Restraint Policy and Procedure. Recommendations were followed-up by the Unit Managers. · The Interdisciplinary Team was re-educated to the Restraint Policy and Procedure by 4/15/11, by the DNS/designee. · Nursing employees were re-educated to the facility restraint policy and procedure by 4/15/11, by the DNS/designee. · The charge nurse and/or Unit Manager will monitor residents with restraints during daily rounds to ensure restraints are checked and released per protocol and the documentation is reflective of appropriate restraint release. The Interdisciplinary Team will review residents with restraints no less frequently than quarterly, or with a significant change of condition, to ensure the least restrictive device is utilized. · Residents with a physical restraint will be assessed monthly and restraint reduction attempts will be made. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance**	

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	devices..." A "PHYSICAL RESTRAINT ASSESSMENT" dated 8/13/10, indicated the medical symptoms/diagnosis that lead to the use of the restraint was "repeated falls." The current order for physical restraint was self release velcro belt with alarm when up in wheelchair. The Interdisciplinary Team Progress Notes indicated: 8/4/11 at 11:30 a.m., "IDT (Interdisciplinary Team) met to review unassisted fall witnessed on 8/3/10 at 11:15 a.m...Res was in w/c (wheelchair). PAC (chair alarm) sounded CNA responded assisted res into w/c was propelling res down hall in w/c when she stood & fell...Res to be ambulated to & from		**program will be put into place** A Restraint CQI tool is utilized weekly x 4, monthly x 2, and quarterly, thereafter, to monitor compliance with resident restraint assessment, implementation and documentation. The audits are reviewed by the CQI committee and action plans are developed, as needed, to improve performance.	

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	meals & when noted to be attempting to stand from w/c..." 8/10/10 at 12:15 p.m., " SS (Social Services), DNS (Director of Nursing Services), UM (unit manager) meet c (with) Res's (Resident's) dau (daughter) (name) & son (son's name). (Resident daughter's name) & (Resident's son's name) expressed concern over the number of falls that (Resident #89's name) had. They were insistent that they do not want to see (Resident #89) receive any broken bones or serious injuries...Interventions that have already been put into place in attempts to prevent further falls were reviewed c (Son and Daughter's names)... (Daughter and Son's names) expressed their thankfulness c all the interventions attempted,			

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	but verbalized their desire for a restraint...It was explained that if a restraint is to be used that it must start with the least restrictive, which would be a self release belt to w/c. It was explained that this item would have to be ordered...After review of possible risks/consequences of use of self release belt (Daughter and Son's names) still requested the use of said restraint. It was noted that the process of ordering said restraint would be initiated." 8/13/10 at 1 p.m., "Self releasing velcro seat belt c alarm initiated as ordered. No (indicated by a o) attempts noted to release belt at this time. Belt was released during meal. 30 day restraint review completed et restraint assessment completed.			

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	Resident able to propel self in w/c without difficulty..." 9/14/10 at 10:30 a.m., "IDT met to review for 30 day restraint review. Res has tolerated self release velcro belt c alarm well...no (indicated by a o) falls since initiation. Spoke with res daughter (name) & she is happy c use & has not noted any change in res cognitive or psychosocial states 2o (secondary to) use..." The "30 Day Restraint Review" forms, dated 10/12/10, 11/10/10, 12/8/10, 1/5/11, 2/2/11, and 3/2/11, all indicated the resident used a self release velcro belt with alarm . The rationales for the continued use of the restraint were "safety impairment 2o cognitive loss dx (diagnoses) Alzheimer's, senile dementia..."			

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Resident #89 was observed sitting in her wheelchair with the velcro belt fastened across her lap at the following times:
3/7/11 at 12:13 p.m.
3/8/11 at 8:25 a.m. and 1:22 p.m.
3/9/11 at 9:29 a.m.

During an interview on 3/8/11 at 11:25 a.m., the West Unit Manager indicated, the restraint was reviewed every month. She indicated the resident had been falling prior to applying the restraint. She indicated there had not been any attempts to reduce the restraint and they needed to attempt to reduce the resident's restraint.

A policy, titled "Physical Restraints" dated 3/10, provided by the DNS as

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	current, indicated "...Restraint use will be considered only after less restrictive measures have failed, and the interdisciplinary team determines that they are need to treat resident (s) medical symptoms...A physical restraint assessment will be completed prior to the initiation of a restraint...The use of physical restraint will be discussed with the resident (if able), family member...* Restraints cannot be used because of a family request in the absence of a medical symptom...The care plan will be updated to include reason for restraint use and reduction plans..." 3.1-3(w) 3.1-26(a) 3.1-26(g)			

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F0225 SS=D	Based on record review and interview, the facility failed to investigate and report an allegation of abuse to the Indiana State Department of Health (ISDH) timely and failed to ensure the residents of the facility were protected for further abuse for 1 of 24 residents reviewed in a sample of 24. (Resident E) Findings include: Resident E's record was reviewed on 3/10/11 at 9 a.m. Resident E's diagnoses included, but were not limited to, hypothyroidism, congestive heart failure, and convulsions. A Quarterly Minimum Data Set (MDS) Assessment, dated 2/4/11, indicated the resident's cognitive score was 15 (cognition intact). During an interview with Resident E, on 3/10/11 at 10:30 a.m., she indicated the staff treated her "ok." Asked her if any staff member has ever been mean or yelled at her, she indicated "one, she's gone." Asked if everything was ok now, she indicated "yes." During an interview with Resident E, on 3/10/11 at 11 a.m., she indicated she reported the aide to Social Service #4 a couple days after if happened and she said she would take care of it. She indicated it happened around Christmas but could not recall what day it happened. She indicated the	F0225	**F225 INVESTIGATE/ REPORT ALLEGATIONS/ INDIVIDUALS** The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence	04/15/2011

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	aide was taken off her hall. The resident's record lacked any documentation in the Social Services Notes or Nurses Notes regarding the allegation. During an interview with Social Service #4 , on 3/10/11 at 11:21 a.m., she indicated "I vaguely remember having a complaint about (CNA #3). Let me see if I can find anything about it." During an interview with Social Service #4, on 3/10/11 at 11:35 a.m., she indicated "I have no record about this, I don't remember her complaint about verbal abuse from (CNA #3). I remember her complaining about her rushing with care. I'm sure I spoke with (CNA #3) about that." During an interview with the West Unit Manager, on 3/10/11 at 11:47 a.m., she indicated "I may have taken (CNA #3) off the hall, I don't remember. If there was an allegation of abuse, you don't just move them off the hall, you would do an investigation, inform DoN, talk with the resident and get statements, and the CNA would be suspended pending an investigation." During an interview with the DoN, on 3/10/11 at 11:57 a.m., she indicated she did not know anything about an allegation of abuse. She indicated "Social Service (#4) should have immediately reported it...she didn't follow our policy. The CNA would have been removed off of the schedule, staff interviewed and Executive Director would have been notified immediately." During an interview with Resident E, on 3/10/11 at 12:10 p.m., she indicated CNA #3 yelled at her "don't be so picky" and then said "f*** you." "I was eating in my room and had asked her to put		that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** There is no corrective action for resident #E since the alleged deficiency was in the past. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** · All residents have the potential to be affected by the alleged deficient practice. · All staff will be educated by the Director of Nursing Services/designee on the Abuse Policy and Reporting by 4/15/11. **What measures will be put into place or what systemic changes**	

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	my bag of chips on the table. She got pulled out of my room by (RN #2), she overheard her. (CNA # 3) came back later to take care of me and she was nice then. A couple days later she came back and was still saying the 'f' word, but she was not directing it toward me, I didn't feel threatened." During an interview with RN #2, on 3/10/11 at 2 p.m., she indicated "I pulled (CNA #3) out of (Resident E's) room because I could tell she was getting frustrated because she couldn't figure out what she was saying. (Resident E) was eating in her room. I heard (CNA #3) say I don't know what you want. I then switched another CNA, told (CNA #3) to take a break to calm down. I did not hear (CNA #3) curse or yell at (Resident E). I just happened to be going by the door. I am not sure who the other CNA was that I had her switch with. I do not remember what day this happened. I told the West Unit Manager so she would know why I switched people around for that meal. (Resident E) was trying to communicate about her food and I don't believe there was any abuse, otherwise I would have removed the CNA and reported it." During an interview with the Executive Director, on 3/10/11 at 2:25 p.m., he indicated the first time he heard about the allegation of abuse was today. Review of the CNA staffing assignments, indicated CNA #3 was not assigned to take care of Resident E after 12/29/10. Review of CNA #3's employee file, on 3/10/11 at 11 a.m., indicated she resigned on 1/27/11. During an interview with the DoN, on 3/10/11 at 3 p.m., she indicated she was going to go interview Resident E and do the investigation. "I do not allow staff to speak to residents that way; they		**you will make to ensure that the deficient practice does not recur** · All staff will be inserviced monthly on the Abuse Policy at the all staff meeting by the SDC/designee ongoing. · During Customer Care rounds residents will be interviewed routinely regarding any concerns regarding resident's rights and abuse. Findings will be documented on the Daily Rounds Checklist and addressed immediately. · The Daily Rounds Checklists will be reviewed during daily meetings by the ED/designee for compliance. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** · **An "Abuse Prohibition and Investigation" CQI tool will be utilized weekly x 4, then monthly thereafter.** · **Data will be submitted to the CQI Committee for review and follow up.** · **Action plans will be developed as needed for issues identified to improve compliance.**	

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	155166	A. BUILDING _____ B. WING _____	03/15/2011

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	need to be professional and polite." During an interview with the resident's daughter, on 3/11/11 at 4:15 p.m., she indicated "the staff are really good, but Mom had an issue with an aide at the end of last year or the beginning of this year, somewhere around there. I called and spoke with the DoN for the aide to be taken off her hall. There have been no further issues." A facility policy titled," Abuse Prohibition, Reporting, And Investigation," dated February 2010, indicated "...Policy/Procedure...5. All abuse allegations/abuse must be reported to the Executive Director immediately...Resident Abuse...Procedure:...4. The Executive Director and/or Director of Nursing will be notified of the report and the initiation of the investigation...14. The Executive Director and/or Director of Nursing is responsible for notifying...Indiana State Department of Health...16. The Executive Director or the Director of Nursing is responsible to coordinate all investigation processes, assure as accurate and complete written record of the incident and investigation, and to file up a written report to the Indiana State Department of Health within five (5) working days." This Federal tag relates to complaint IN00087434. 3.1-28(d)			

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F0226 SS=D	Based on record review and interview, the facility failed to follow the facility's policy for investigating and reporting to the Indiana State Department of Health (ISDH) an allegation of abuse, for 1 of 24 residents reviewed for abuse in a sample of 24. (Resident #E) Findings include: A facility policy titled," Abuse Prohibition, Reporting, And Investigation," dated February 2010, indicated "...Policy/Procedure...5. All abuse allegations/abuse must be reported to the Executive Director immediately...Resident Abuse...Procedure:...4. The Executive Director and/or Director of Nursing will be notified of the report and the initiation of the investigation...14. The Executive Director and/or Director of Nursing is responsible for notifying...Indiana State Department of Health...16. The Executive Director or the Director of Nursing is responsible to coordinate all investigation processes, assure as accurate and complete written record of the incident and investigation, and to file up a written report to the Indiana State Department of Health within five (5) working days." Resident E's record was reviewed on 3/10/11 at 9 a.m. Resident E's diagnoses included, but were not limited to, hypothyroidism, congestive heart failure, and convulsions. A Quarterly Minimum Data Set (MDS) Assessment, dated 2/4/11, indicated the	F0226	**F226 DEVELOP/IMPLEMENT ABUSE/NEGLECT, ETC POLICIES** The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** · There is no corrective action for resident #E since the alleged deficiency was in the past. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken· All residents have the potential to be affected by the alleged deficient practice. · All staff will be educated by the Director of Nursing Services/designee on the Abuse Policy and Reporting by 4/15/11. What measures will be put into place or what systemic changes you will**	04/15/2011

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	resident's cognitive score was 15 (cognition intact). During an interview with Resident E, on 3/10/11 at 10:30 a.m., she indicated the staff treated her "ok." Asked her if any staff member has ever been mean or yelled at her, she indicated "one, she's gone." Asked if everything was ok now, she indicated "yes." During an interview with Resident E, on 3/10/11 at 11 a.m., she indicated she reported the aide to Social Service #4 a couple days after if happened and she said she would take care of it. She indicated it happened around Christmas but could not recall what day it happened. She indicated the aide was taken off her hall. The resident's record lacked any documentation in the Social Services Notes or Nurses Notes regarding the allegation. During an interview with Social Service #4 , on 3/10/11 at 11:21 a.m., she indicated "I vaguely remember having a complaint about (CNA #3). Let me see if I can find anything about it." During an interview with Social Service #4, on 3/10/11 at 11:35 a.m., she indicated "I have no record about this, I don't remember her complaint about verbal abuse from (CNA #3). I remember her complaining about her rushing with care. I'm sure I spoke with (CNA #3) about that." During an interview with the West Unit Manager, on 3/10/11 at 11:47 a.m., she indicated "I may have taken (CNA #3) off the hall, I don't remember. If there was an allegation of abuse, you don't just move them off the hall, you would do an		**make to ensure that the deficient practice does not recur · All staff will be inserviced monthly on the Abuse Policy at the all staff meeting by the SDC/designee ongoing. · During Customer Care rounds residents will be interviewed routinely regarding any concerns regarding resident's rights and abuse. Findings will be documented on the Daily Rounds Checklist and addressed immediately. · The Daily Rounds Checklists will be reviewed during daily meetings by the ED/designee for compliance. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place · An "Abuse Prohibition and Investigation" CQI tool will be utilized weekly x 4, then monthly thereafter.· Data will be submitted to the CQI Committee for review and follow up. · Action plans will be developed as needed for issues identified to improve compliance.**	

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	investigation, inform DoN, talk with the resident and get statements, and the CNA would be suspended pending an investigation." During an interview with the DoN, on 3/10/11 at 11:57 a.m., she indicated she did not know anything about an allegation of abuse. She indicated "Social Service (#4) should have immediately reported it...she didn't follow our policy. The CNA would have been removed off of the schedule, staff interviewed and Executive Director would have been notified immediately." During an interview with Resident E, on 3/10/11 at 12:10 p.m., she indicated CNA #3 yelled at her "don't be so picky" and then said "f*** you." "I was eating in my room and had asked her to put my bag of chips on the table. She got pulled out of my room by (RN #2), she overheard her. (CNA # 3) came back later to take care of me and she was nice then. A couple days later she came back and was still saying the 'f' word, but she was not directing it toward me, I didn't feel threatened." During an interview with RN #2, on 3/10/11 at 2 p.m., she indicated "I pulled (CNA #3) out of (Resident E's) room because I could tell she was getting frustrated because she couldn't figure out what she was saying. (Resident E) was eating in her room. I heard (CNA #3) say I don't know what you want. I then switched another CNA, told (CNA #3) to take a break to calm down. I did not hear (CNA #3) curse or yell at (Resident E). I just happened to be going by the door. I am not sure who the other CNA was that I had her switch with. I do not remember what day this happened. I told the West Unit Manager so she would know why I switched people around for that meal. (Resident E) was trying to communicate about her food and I don't believe there was any abuse, otherwise I			

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	would have removed the CNA and reported it." During an interview with the Executive Director, on 3/10/11 at 2:25 p.m., he indicated the first time he heard about the allegation of abuse was today. Review of the CNA staffing assignments, indicated CNA #3 was not assigned to take care of Resident E after 12/29/10. Review of CNA #3's employee file, on 3/10/11 at 11 a.m., indicated she resigned on 1/27/11. During an interview with the DoN, on 3/10/11 at 3 p.m., she indicated she was going to go interview Resident E and do the investigation. "I do not allow staff to speak to residents that way; they need to be professional and polite." During an interview with the resident's daughter, on 3/11/11 at 4:15 p.m., she indicated "the staff are really good, but Mom had an issue with an aide at the end of last year or the beginning of this year, somewhere around there. I called and spoke with the DoN for the aide to be taken off her hall. There have been no further issues." This federal tag relates to complaint IN00087434. 3.1-28(a)			

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F0253 SS=E	Based on observation and interview, the facility failed to maintain a clean and comfortable environment on 2 of 2 units (West and East Unit), related to, dirt and dust accumulation along the base boards on 4 halls of the West Unit (Front, Vent, Viking, and South hall), which could affect 79 residents who reside on the West Unit, a missing piece of linoleum in the floor of room 219, chrome cover off of the bedside table and dirty feeding tube pole in room 213, scratches and indents on the toilet seat and dirty commode cover lids in the bathroom of 239, dirty privacy curtains in rooms 205, 297, and 239, and a dirty toilet seat riser in the bathroom of room 107 on the East Unit, which could affect 43 residents who resident on the East Unit.. Findings include: During the environmental tour on 03/09/11 at 9:15 a.m. through 10:20 a.m., with the Maintenance Supervisor and the Housekeeping Supervisor, the following was observed: 1) West Unit: A) There was an accumulation of dust and dirt along the base boards of both sides of the hallways on the Front, Vent,	F0253	F253 HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** · Baseboards have been cleaned. The linoleum in Room 219 was replaced. The over bed table in Room 213 was replaced. Toilet seat in room 239 was replaced. Privacy curtains were cleaned for rooms 247, 205, 207. The toilet riser in room 107 was cleaned. All feeding poles have been cleaned. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** **· All residents have the potential to be effected by the alleged deficient practice.** · All staff will be inserviced on the use of maintenance requests by 4/15/11. · The housekeeping staff will be inserviced on the use of cleaning schedules by 4/15/11. What measures will be put into place or what systemic changes you will make to ensure that the	04/15/2011

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	Viking, and South hall on the West Unit. During an interview at the time of the observation, the Housekeeping Supervisor indicated they dust mop the hallway daily. She indicated they use the buffer and wet mop weekly. During an interview on 03/09/11 at 2:15 p.m., the Administrator indicated when they use the floor buffer, the dirt spreads to the baseboard. He indicated he had informed the Housekeeping Department a few weeks ago the baseboard needed cleaned. B) There was a piece of linoleum missing out of the floor under bed A in room 219. During an interview at the time of the observation, the Maintenance Supervisor indicated he was unaware of the missing linoleum. C) There was an over the bed table with missing chrome on the base of the table and a feeding tube pole with a light brown, dried substance on the base of the pole in room 213, bed A. During an interview at the time of the observation, the Maintenance Supervisor indicated the table needed thrown out and		deficient practice does not recur · The Housekeeping/Laundry Supervisor will complete random room checks weekly. · The Maintenance Supervisor/designee will complete rounds monthly and repair areas as needed. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place The Housekeeping/Laundry Supervisor will document findings on the Quality Control Inspection form. · The Maintenance Supervisor will document findings and repairs in the Preventative Maintenance Manual. The Executive Director/designee will review the information monthly to ensure compliance. · Data will be submitted to the CQI Committee for review and follow up. · Action plans will be developed as needed for issues identified to improve compliance.	

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	the Housekeeping Supervisor indicated the feeding pole needed cleaned. D) The bathroom in room 239, the toilet seat had scratches and indentations and there were two empty commode buckets with dirty lids stored under the sink in the bathroom. During the interview at the time of the observation, the Housekeeping Supervisor indicated the toilet usually has another toilet seat that rolls over the toilet. E) There were brown spots on the privacy curtains in room 247, beds A and B. During an interview at the time of the observation, the Housekeeping Supervisor indicated the curtains are washed yearly or more often if needed. She indicated they are suppose to check the curtains daily when they clean the room. F) There were brown spots on the privacy curtain in room 205, bed B. G) There were brown spots on the privacy curtain in room 207, bed A. 2) East Wing: A) The toilet riser in the bathroom of			

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	107 had a dried red substance all over the back of the toilet seat. During an interview at the time of the observation, the Housekeeping Supervisor indicated the room had already been cleaned. 3.1-19(f)			

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F0282 SS=D	Based on observation, record review, and interview, the facility failed to ensure each resident's plan of care and physician's orders were followed related to blood sugar checks, insulin administration, behavioral interventions, and laboratory tests, for 2 of 24 residents reviewed for following physician's orders and plans of care in a sample of 24 residents (Residents F and N) Findings Include: 1. Resident F's record was reviewed on 3/10/11 at 9:00 a.m. Resident F's diagnoses included, but were not limited to, Diabetes Mellitus and hypertension. The physician's order	F0282	**F282 SERVICES BY QUALIFIED PERSONS/PER CARE PLAN** The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** · There are no corrective actions for Resident #F and Resident #N because the alleged deficient practice is in the past. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** Residents with physician orders have the potential to be affected by the alleged deficient practice. · Licensed nurses will be re-educated on following physician orders by the DNS/designee by 4/15/11. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur** · The Interdisciplinary Team reviews the physician orders at	04/15/2011

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	recapitulation, dated 3/11, indicated "11/27/10 accu checks (blood sugar checks) three times daily...10/19/10 Novolog (insulin)..inject sub-q (subcutaneously) per sliding scale (administered per blood sugar result) : 70-150 =0 units, 151-200 =2 units, 201-250 = 4 units, 251-300 = 6 units, 301-350=8 units, 351-400= 10 units, > (greater than) 400 call MD. 12/9/10 Lantus (insulin)...inject 15 units sub-q daily at bedtime. 12/9/10 Lantus...inject 15 units sub-q daily in the morning." A blood glucose monitoring tool, dated 12/10, indicated blood sugars were to be done three times a day at 6 a.m., 4 p.m., and 9 p.m. The form indicated the following blood sugar results:		the clinical meeting (Mon-Fri). · The Interdisciplinary Team reviews the Lab Tracking Log at the clinical meeting (Mon-Fri). · The Unit Manager/designee will audit the Capillary Blood Glucose Monitoring Tool daily (Mon – Fri, excluding holidays) to monitor for compliance with physician orders. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** · A "Medication Administration" and "Labs/Diagnostics" CQI tool will be utilized weekly x 4, then monthly thereafter. · **Data will be submitted to the CQI Committee for review and follow up.** · Noncompliance with facility procedures may result in disciplinary action.	

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	12/1/10 at 9 p.m., 253 and the Lantus insulin was administered but no novolog insulin was administered per the sliding scale. 12/5/10 at 9 p.m., 212 and the Lantus insulin was administered but no novolog insulin was administered per the sliding scale. 12/7/10 at 9 p.m., 218 and no novolog insulin was administered per the sliding scale. 12/8/10 at 9 p.m., 209 and the Lantus insulin was administered but no novolog insulin was administered per the sliding scale. 12/9/10 at 4 p.m., 232 and 8 units of novolog insulin was administered instead of the 4 units as ordered. 12/12/10 at 9 p.m., 282 and the Lantus insulin was			

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	administered but no novolog insulin was administered per the sliding scale. 12/16/10 at 9 p.m.,183 and the Lantus insulin was administered but no novolog insulin was administered per the sliding scale. 12/17/10 at 9 p.m., 214 and the Lantus insulin was administered but no novolog insulin was administered per the sliding scale. 12/18/10 at 9 p.m., 176 and the Lantus insulin was administered but no novolog insulin was administered per the sliding scale. 12/21/10 at 9 p.m., 249 and the Lantus insulin was administered but no novolog insulin was administered per the sliding scale. 12/24/10 at 9 p.m., 232 and the Lantus insulin was			

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	155166	A. BUILDING _____ B. WING _____	03/15/2011

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	administered but no novolog insulin was administered per the sliding scale. 12/25/10 at 9 p.m., 251 and the Lantus insulin was administered but no novolog insulin was administered per the sliding scale. A blood glucose monitoring tool, dated 1/11, indicated the blood sugars were to be done three times a day at 6 a.m., 4 p.m., and 9 p.m. The form indicated : 1/1/11, no blood sugar check or sliding scale insulin administration at 6 a.m. 1/3/11, no blood sugar check or sliding scale insulin administration at 9 p.m. 1/7/11, no blood sugar check or sliding scale insulin administration at 9 p.m. 1/8/11, no blood sugar check or			

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	sliding scale insulin administration at 9 p.m. 1/10/11, no blood sugar check or sliding scale insulin administration at 9 p.m. 1/12/11, no blood sugar check or sliding scale insulin administration at 9 p.m. 1/13/11, no blood sugar check or sliding scale insulin administration at 9 p.m. 1/18/11, no blood sugar check or sliding scale insulin administration at 6 a.m. 1/19/11, no blood sugar check or sliding scale insulin administration at 6 a.m. 1/23/11 at 4 p.m., the resident's blood sugar results were 314 and 4 units of novolog insulin was administered when 8 units should have been administered per the physician's order. 1/28/11, no blood sugar check or sliding scale insulin			

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	administration at 9 p.m. 1/29/11, no blood sugar check or sliding scale insulin administration at 9 p.m. During an interview on 3/10/11 at 9:22 a.m., the West Unit Manager, indicated the resident's blood sugar checks and insulin had not been administered as ordered by the physician. During an interview on 3/10/11 at 3 p.m., the DNS (Director of Nursing Services) indicated the resident's blood sugars and insulin administration were a "mess." 2. Resident N's record was reviewed on 3/8/11 at 1:30 p.m. Resident N's diagnoses included, but were not limited to, depression, hypertension,			

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	and epilepsy. a) A physician's order, dated 3/4/11, indicated "...check PT/INR Protime and International normalized ration) (laboratory tests for blood clotting) on 3/7/11." The resident's record lacked documentation of the PT/INR laboratory test results. During an interview on 3/8/11 at 2:10 p.m., RN #9 indicated the laboratory test had not been done as ordered. She indicated the nurse who had taken the order had not completed a laboratory requisition for the PT/INR for 3/7/11, so it had not been drawn. b) Resident N's Social Service Progress Notes, dated 2/4/11 at			

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	9 a.m., indicated "Res (Resident) had behavior on 2/4/11 at 2:30 a. Nrsg (Nursing) observed res chewing on his brief. Nrsg talked c (with) Res...Writer discussed c res the health issues involved c res placing non-food substance in his mouth...Nrsg to provide cloth briefs only to res." A care plan, dated 11/16/10, indicated "...Res places non-food items in mouth...Approach...Res to have cloth briefs only." Resident N was observed on 3/7/11 at 12:13 p.m., and 3/8/11 at 2:00 p.m., with disposable incontinence briefs on instead of cloth briefs. During an interview on 3/8/11			

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	at 2:00 p.m., RN #9 indicated the resident did not have cloth briefs on. This federal tag relates to complaint IN00087434. 3.1-35(g)(2)			

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F0309 SS=D	Based on record review and interview, the facility failed to provide the necessary care and services related to administering as needed (prn) pain medication to a resident who was screaming with pain, for 1 of 24 residents reviewed for providing the necessary care and services in a sample of 24 residents. (Resident #89) Findings include: Resident #89's record was reviewed on 3/8/11 at 9:23 a.m. Resident #89's diagnoses included, but were not limited to, Alzheimer's disease, arthritis, and stroke. The physician's order recapitulation, dated 3/11, indicated an order for Tylenol 325 milligrams two tablets	F0309	**F309 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING** Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** · There is no corrective action for resident #89 since the alleged deficiency was in the past. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** · All residents have the potential to be affected by the alleged deficient practice. · Nurses will be educated on assessment and intervention regarding residents in pain by the SDC/designee by 4/15/11. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur** · **Unit Manager/designee will audit the 24-hour reports**	04/15/2011

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	every 6 hours as needed for pain scale of 1-10, dated 8/4/10. A nurses' note, dated 1/31/11 at 6 a.m., indicated "Yelling/screaming upon movement for care et (and) transfers. Very stiff in some joints. MD paged." The MAR (medication administration record), dated 1/11, indicated the as needed Tylenol had not been administrated when the resident had been yelling/screaming in pain. A physician's order dated 1/31/11 at 8 a.m., indicated "Xray bilateral hips and pelvis DX (diagnosis) pain..." The x-ray results, dated		**daily in clinical meeting (Mon-Fri) for change in resident condition including pain. Any resident with a change of condition will be reviewed for appropriate intervention and documentation.** How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place · A "24 Hour Condition Report" CQI tool will be utilized weekly x 4, then monthly thereafter. · Data will be submitted to the CQI Committee for review and follow up. · Noncompliance with facility procedures may result in disciplinary action.	

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	1/31/11, indicated no abnormalities. During an interview on 3/8/11 at 11:25 a.m., the West Unit Manager indicated, the nurse should have administered the as needed pain medication on 1/31/11 at 6 a.m. She indicated she would check the 24 hour report sheet to see if the nurse had put she had administered the prn Tylenol on there. During an interview on 3/10/11 at 9:22 a.m., the West Unit Manager indicated, there was not any information on the 24 hour report for the Tylenol being administered on 1/31/11. 3.1-37(a)			

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F0323 SS=G	Based on record review and interview, the facility failed to ensure a resident received adequate supervision and assistance to prevent accidents related to an unsafe transfer due to transferring a resident without the indicated amount of assistance, which resulted in a fracture of the resident's leg, for 1 of 11 residents reviewed who required the use of a hoyer lift for transfers in a sample of 24 and failed to implement fall interventions to prevent further falls for 1 of 7 residents reviewed for falls in a sample of 24 residents. (Resident #74 and #131) Findings include: 1. Resident #74's record was reviewed on 3/8/11 at 8:52 a.m. Resident #74's diagnoses included, but were not limited to, traumatic brain injury and fractured tibia and fibula. A quarterly MDS (Minimum Data Set) assessment, dated 2/23/11, indicated Resident #74 cognitive status was intact, and dependent on two staff for bed mobility, transfer, toilet use and bathing. The MDS assessment lacked documentation of the resident having falls since admission. A care plan for risk for falls, dated 10/19/10, indicated "hoyer lift and 2 staff...." A Resident Care/Need sheet, dated 11/19/10, indicated Resident #74 required a hoyer lift with two assist. A Nurses' Note, dated 11/20/10 at 10:00 a.m.,	F0323	**F323 FREE OF ACCIDENTS/HAZARDS/ SUPERVISION/DEVICES** The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents This tag is being disputed. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** · There is no corrective action for resident #74 and resident #131 since the alleged deficiency was in the past. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** · Residents residing in the facility have the potential to be affected by the alleged deficient practice. · The SDC/designee will complete Inservice for staff on Fall Prevention Interventions and the use of Mechanical Lifts by 4/15/11. **What measures will be put into place or what systemic**	04/15/2011

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	indicated "CNA's put res (resident) in bed for rest, writer called to room. Res L (left) knee area & (and) outer side c/ (with) 15 cm (centimeters) x (by) 8 cm purple blue bruise et (and) swollen from knee & ankle, warm to touch but not excessive.... A Nurses' Notes, dated 11/20/10 at 1:00 p.m. indicated the resident was admitted to the hospital. A History and Physical from the hospital, dated 11/20/10, indicated "...Acute fractured tibia and fibula...." Review of the facility's investigative report, dated 11/20/11, indicated the CNA providing Resident #74's care transferred the resident using a hoyer lift by herself into the wheelchair. The report indicated the CNA did not follow the resident's care plan of using two staff members when using a hoyer lift. During an interview on 3/8/11 at 1:20 p.m., the DoN (Director of Nursing) indicated the CNA did not follow the transfer policy. The DoN indicated she thought the CNA "tried to cut corners" and placed the resident in the wheelchair by standing him up and not using the hoyer lift. The DoN indicated another CNA had seen the resident sitting on the edge of his wheelchair and the resident was yelling. The DoN indicated the CNA got help and when they placed the resident into the bed they noticed the discoloration of the resident's leg. A professional resource, titled, "Indiana State Department of Health Division of Long Term Care Nurse Aide Training Program July 1998", Topic 22 Transferring, indicated, "...4. A		**changes you will make to ensure that the deficient practice does not recur** · Unit Managers monitor resident care by making rounds on their units. Concerns are addressed with the nursing aide, as needed. Rounds are completed each shift by the charge nurse, Monday – Friday, by department heads, to monitor resident care. Concerns are addressed with the resident's charge nurse · utilizing an inservice and/or disciplinary action. · The Director of Nursing Services is responsible to monitor for facility compliance. · Unit Managers are responsible to ensure residents receive the necessary fall prevention measures they require. · Nursing staff will complete skills validations Mechanical Lift usage by 4/15/11. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** · Observations will be documented on the "Nursing Rounds Checklist" and "Mechanical Lift Transfers" CQI tools weekly x 4, then monthly	

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	mechanical lift..have at least one co-worker assist when using a mechanical lift..." 2. Resident #131's record was reviewed on 3/9/11 at 1:10 p.m. Resident #131's diagnoses included, but were not limited to, dementia, bronchitis and hypertension. An admission MDS assessment, dated 1/13/11, indicated Resident #131's cognitive status was intact, required limited assistance of one staff member for transfer, toilet use and bathing. The admission MDS assessment indicated the resident had fallen prior to admission and had fractured in a fall. A fall care plan, dated 12/13/10, indicated the intervention to keep the resident's wheelchair at bedside and easily accessible was added on 2/7/10. A Resident Care/Need sheet, dated 2/21/11, indicated '...Place w/c next to bed when res in bed...." An IDT (Interdisciplinary Team) progress note, dated 2/7/11, indicated "...Fall on 2/6/11 at 7:45 p.m. Res was in his room in bed & stood up from bed, walked over to room mates side of bed to get his w/c (wheelchair) & walked backwards c/ w/c		thereafter. · Data will be submitted to the CQI Committee for review and follow up. · Noncompliance with facility procedures may result in disciplinary action.	

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	& fell to floor on buttocks & back hitting wall...w/c to be kept @ (at) bedside & easily accessible...." A Nurses' Note, dated 2/20/11 at 6:00 p.m., indicated "Res found on floor in front of bed on buttocks. Fall charting started c/ neuro assessments...small abrasion noted to L rear thigh...." A Fall Circumstance Report, dated 2/20/11, indicated "...he said he reached for his chair and it was not there..." During an interview on 3/9/11 at 2:05 p.m., the West Hall Unit Manager indicated the resident's wheelchair was not in place. 3.1-45(a)(1) 3.1-45(a)(2)			

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F0328 SS=D	Based on observation, record review, and interview, the facility failed to ensure oxygen was administered as ordered by the physician for 1 of 7 residents reviewed for oxygen in a sample of 24 residents. (Resident #138) Findings include: During the initial tour with RN#1 on 3/7/11 at 10:30 a.m., Resident #138 was observed laying in her bed. The resident's oxygen was set on 4.5 liters. RN #1 indicated the resident's oxygen was on 4.5 liters. Resident #138 was observed on 3/8/11 at 8:45 a.m. and 11:28 a.m., with her oxygen level set on 4 liters. Resident #138 was observed on 3/8/11 at 1:50 p.m., with the oxygen level set on 4 liters. During an interview on 3/8/11 at 2:38 p.m., RN #1 indicated the resident's oxygen was set on 4 liters. Resident #138's record was reviewed on 3/8/11 at 11:30 a.m. Resident #138's diagnoses included, but were not limited to, congestive heart failure, hypertension, and depression. A physician's order, dated 4/26/10, indicated the oxygen was 5 liters per nasal cannula. During an interview on 3/8/11 at 2:43 p.m., Respiratory Therapist #5 indicated the oxygen should be set at 5 liters. 3.1-47(a)(6)	F0328	**F328 TREATMENT/CARE FOR SPECIAL NEEDS** The facility must ensure that residents receive proper treatment and care for the following special services: Injections, parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Trachesostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** · There is no corrective action for resident #138 since the alleged deficiency was in the past. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** · Residents who use oxygen have the potential to be affected by the alleged deficient practice. · Licensed nurses and respiratory staff will be re-educated on following physician orders by the SDC/designee by 4/15/11. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur** The interdisciplinary team will review the “24 Hour Report” and “Physician Telephone Order” forms for changes in oxygen settings Monday – Friday ·	04/15/2011

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			(excluding holidays) at the Clinical Meeting. The interdisciplinary team determines if any further interventions or changes to the plan of care is necessary. The Respiratory Supervisor/designee will ensure compliance. · Respiratory Supervisor/designee is responsible to ensure compliance with facility procedure for compliance with physician orders.**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** · Respiratory Supervisor/designee will complete the "Oxygen Therapy" CQI tool 3 times weekly x 4, the once weekly x 4 weeks and then monthly thereafter.· Data will be submitted to the CQI Committee for review and follow up. · Noncompliance with facility procedures may result in disciplinary action.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0365 SS=E	Based on observation, record review, and interview, the facility failed to provide residents' food in a form designed to meet the residents' needs, related to serving regular pieces of meat to residents on a mechanical soft diet for 2 residents in a sample of 24 (residents #57 and #89) and 2 residents in a supplemental sample of 20 (residents #49 and #62). This had the potential to affect 12 residents in the facility with physician's orders for a mechanical soft diet. Findings include: During an observation of the evening meal on 03/08/11 the following was observed: A) At 5:35 p.m. in the West Unit dining room, resident #89 received her supper, which included beef and noodles. The beef was served in approximate 1/2 inch cubes. During an interview at the time of the observation, the Registered Dietician Manager indicated the meat was not ground and she indicated she would replace the beef and noodles with the correct diet. B) At 5:40 p.m. resident #57 received her	F0365	**F365 FOOD IN FORM TO MEET INDIVIDUAL NEEDS** Each resident receives and the facility provides food prepared in a form designed to meet individual needs.**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** · The meals for Resident #57, #89, #49 and #62 were removed and they were given the correct item per the Modified Diet Spreadsheet. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** · Residents residing in the facility have the potential to be affected by the alleged deficient practice. · The Dietary staff was inserviced on Mechanical Soft/Ground Meat by the RD on 3/9/11. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur** · The Dietary Manager will verify food consistency once the meal has been prepared. ·	04/15/2011

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	155166	A. BUILDING _____ B. WING _____	03/15/2011

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	diet in the East Unit dining room, which included beef and noodles. The beef was served in approximate 1/2 inch cubes. The meat could not be cut with a fork. Resident #49 received her diet in the East Unit dining room, which included regular beef and noodles. During an interview at the time of the observation, the Registered Dietician Manager indicated the residents had received regular meat. C) At 5:50 p.m., Resident #62 had received his meal tray in his room. The resident received regular beef and noodles. Review of the facility's Modified Diet Spreadsheet, dated week 2 day 3 201-2011, indicated the mechanical soft diets were to receive 6 ounces of ground beef and noodles. 1. Resident #62's record was reviewed on 03/08/11 at 6 p.m. The resident's diagnoses included, but were not limited to, Alzheimer's Disease and Congestive heart failure. The resident's Physician's Recapitulation Orders, dated 03/11, indicated an order for		The Dietary Manager will monitor meal service to ensure the Modified Diet Spreadsheet is being followed. **Monitoring will happen daily (Mon-Fri) for 4 weeks, then 3 times weekly x 4 weeks, then weekly x 4 weeks and then monthly thereafter. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place · Observations will be documented on the "Meal Accuracy" CQI tool weekly x 4, then monthly thereafter. · Data will be submitted to the CQI Committee for review and follow up. · Noncompliance with facility procedures may result in disciplinary action.**	

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	a regular diet with ground meat. 2. Resident #89's record was reviewed on 03/08/11 at 6:05 p.m. The resident's diagnoses included, but were not limited to, Alzheimer's Disease and stroke. The resident's Physician's Recapitulation Orders, dated 03/11, indicated an order for mechanical soft meats. 3. Resident #49's record was reviewed on 03/08/11 at 6:10 p.m. The resident's diagnoses included, but were not limited to, Parkinson's Disease and convulsions. The resident's Physician's Recapitulation Orders, dated 03/11, indicated an order for a mechanical soft diet. 4. Resident #57's record was reviewed on 03/07/11 at 2:10 p.m. The resident's diagnoses included, but were not limited to, dementia and hiatal hernia. The resident's Physician's Recapitulation Orders, dated 03/11, indicated an order for a mechanical soft diet. During an interview on 03/09/11 at 8:40 a.m., the Director of Nursing indicated the wrong diets were served to the residents.			

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	3.1-21(a)(3)			

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F0367 SS=D	Based on observation, record review, and interview, the facility failed to provide therapeutic diets as ordered by the resident's physician, related to double portions and fortified food for 3 of 7 residents with physician's orders for nutritional interventions in a sample of 24. (Residents #2, #57, and #74) Findings include: During an observation of the evening meal on 03/08/11 the following was observed: A) At 5:25 p.m., resident #74 received his supper tray. The fluids on his tray included two glasses of juice. B) At 5:40 p.m.,. resident #57 received her supper tray, which included one piece of cake and a carton of whole milk. During an interview at the time of the observation, the Registered Dietician Manager indicated the resident had not received a double dessert. She indicated the fortified food is put into the resident's milk. She indicated the resident had not received fortified food. C) At 6:25 p.m., resident #2 received her	F0367	**F367 THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN** Therapeutic diets must be prescribed by the attending physician. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** · There is no corrective action for resident #2, #57, #74 since the alleged deficiency was in the past. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** · Residents residing in the facility have the potential to be affected by the alleged deficient practice.· The Dietary staff was inserviced on Fortified Foods by the RD on 3/9/11. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur** · Residents receiving fortified foods will have their tray card highlighted so that staff will diligent in serving fortified foods to the residents. · The Dietary	04/15/2011

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	supper meal, which included juice and water for her supper fluids. 1. Resident #57's record was reviewed on 03/07/11 at 2:10 p.m. The resident's diagnoses included, but were not limited to, dementia and hiatal hernia. The resident's Physician's Recapitulation Orders, dated 03/11, indicated an order for fortified food with all meals and double desserts at lunch and dinner. 2. Resident #74's record was reviewed on 03/08/11 at 8:52 a.m. The resident's diagnoses included, but were not limited to, closed head injury and fractured leg. The resident's Physician's Recapitulation Orders, dated 03/11, indicated an order for fortified foods for all meals. 3. Resident #2's record was reviewed on 03/08/11 at 2 p.m. The resident's diagnoses included, but were not limited to, Alzheimer's Disease and hypertension. The resident's Physician's Recapitulation Orders, dated 03/11, indicated an order for fortified foods for all meals. 3.1-21(b)		Manager will monitor meal service to ensure accuracy. **Monitoring will happen daily (Mon-Fri) for 4 weeks, then 3 times weekly x 4 weeks, then weekly x 4 weeks and then monthly thereafter.How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** · Observations will be documented on the "Meal Accuracy" CQI tool weekly x 4, then monthly thereafter. · Data will be submitted to the CQI Committee for review and follow up. · Noncompliance with facility procedures may result in disciplinary action.	

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F0371 SS=F	Based on observation and interview, the facility failed to distribute and serve food under sanitary conditions, related to open and undated food, a dirty plate, dirty shelves, a pencil in the utensil drawer, and a dirty garbage can lid, for 1 of 1 Kitchen, dirty refrigerators, toaster, and outdated supplements for 1 of 2 Nutritional Pantries (East and West Unit), 1 of 1 Activity Room, and 1 of 2 Medication Rooms (East Unit) . This had the potential to affect 120 residents who consumed food prepared in the kitchen, from the East and West pantries, the East medication room or from the activity room out of a total population of 146. Findings include: 1. Kitchen During the initial tour on 03/07/11 at 9:45 a.m. to 10:15 a.m., with the Registered Dietician Manager and the Dietary Services Manager, the following was observed: A. In the walk in freezer, there was a bag of frozen broccoli opened without an open date. At the time of the observation,the Dietary Services Manager threw the broccoli away.	F0371	**F371 SANITARY CONDITIONS** The facility must- (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This tag is being disputed. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** · The Glucerna 1.2 was disposed of 3/9/11. There were no residents on this supplement at the time of survey. · The Activity Room freezer was cleaned 3/9/11. · The toaster was replaced 3/9/11. · The East Unit refrigerator was cleaned 3/9/11. · The Cottage oven was cleaned. · The broccoli was thrown away on 3/9/11. · The plate was re-washed on 3/9/11. · The shelves were cleaned on 3/9/11. The pencil was removed from the · drawer and the utensils were cleaned on 3/9/11. · The garbage can lid was cleaned on 3/9/11.	04/15/2011

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	B. On a shelf with stored and ready to use plates, there were 1 of 4 plates with dried food particles. The Dietary Services Manager took the plate to be rewashed, at the time of the observation. C. A shelf with stored and ready to use plates was dirty. D. A shelf with stored and ready to use hotel pans had dirt and food particles. E. There was a pencil in the utensil drawer. During an interview at the time of the observation, the Registered Dietician Manager indicated "That should not be in there." F. The garbage can lid by the handwashing sink was dirty. During an interview at the time of the observation, the Dietary Services Manager, indicated "I just cleaned it on Friday."		**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** · All residents have the potential to be effected by the alleged deficient practice. · Dietary personnel will be re-educated on kitchen sanitation by the Dietary Manager/designee by 4/15/11. · All staff will be inserviced on proper sanitary conditions by the SDC/designee by 4/15/11. · Noncompliance with facility policy and procedure may result in employee re-education and/or disciplinary action up to and including termination. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur · Dietary personnel will clean their respective areas after each use. · Dietary personnel are responsible for following a cleaning schedule to ensure all areas are cleaned routinely. · The Dietary Consultant/designee will complete a weekly sanitation check x 4, then monthly thereafter, and as needed, to	

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			ensure compliance with kitchen sanitation. · The Dietary Manager is responsible for compliance with kitchen sanitation. The Housekeeping/Laundry Supervisor will complete a sanitation check on the Nutritional Pantry three times weekly for 4 weeks then weekly thereafter.	

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F0371 SS=F	2. During an observation on 03/08/11 at 11:05 of the East Unit Medication Room with the East Unit Manager, there were 17 cans of Glucerna 1.2 calorie (dietary supplement) with an expiration date of 02/01/11. During an interview at the time of the observation, the East Unit Manager indicated the nurses were supposed to check the medication room for expired items. 3. During the environmental tour on 03/09/11 at 9:15 a.m. through 10:20 a.m., with the Maintenance Supervisor and the Housekeeping Supervisor, the following was observed: A) The Activity Room freezer had a dark substance spilled on the inside door and there were crumbs and dirt on the bottom shelf. During an interview at the time of the observation, the Activity Director indicated the freezer was suppose to be cleaned on Monday. B) There was an accumulation of crumbs in the bottom of the toaster located in the West Unit Nutritional Pantry. During an interview at the time of the observation,	F0371	**F371 SANITARY CONDITIONS** The facility must- (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This tag is being disputed. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** · The Glucerna 1.2 was disposed of 3/9/11. There were no residents on this supplement at the time of survey. · The Activity Room freezer was cleaned 3/9/11. · The toaster was replaced 3/9/11. · The East Unit refrigerator was cleaned 3/9/11. · The Cottage oven was cleaned. · The broccoli was thrown away on 3/9/11. · The plate was re-washed on 3/9/11. · The shelves were cleaned on 3/9/11. · The pencil was removed from the drawer and the utensils were cleaned on 3/9/11. · The garbage can lid was cleaned on 3/9/11.	04/15/2011

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	the West Unit Manager indicated she did not know who used the toaster. C) The refrigerator in the East Unit Nourishment Room had a red liquid spilled on the inside and the plastic shelf on the bottom of the refrigerator was cracked. D) There was black debris on the bottom of the oven on the Cottage hall. 3.1-21(i)(3)		**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** · All residents have the potential to be effected by the alleged deficient practice. · Dietary personnel will be re-educated on kitchen sanitation by the Dietary Manager/designee by 4/15/11. · All staff will be inserviced on proper sanitary conditions by the SDC/designee by 4/15/11. · Noncompliance with facility policy and procedure may result in employee re-education and/or disciplinary action up to and including termination. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur · Dietary personnel will clean their respective areas after each use. · Dietary personnel are responsible for following a cleaning schedule to ensure all areas are cleaned routinely. · The Dietary Consultant/designee will complete a weekly sanitation check x 4, then monthly thereafter, and as needed, to	

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			ensure compliance with kitchen sanitation. · The Dietary Manager is responsible for compliance with kitchen sanitation. The Housekeeping/Laundry Supervisor will complete a sanitation check on the Nutritional Pantry three times weekly for 4 weeks then weekly thereafter.	

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F0425 SS=F	Based on observation, interview, and record review, the facility failed to ensure expired medications were discarded and a multiple dose vial of medication was dated when opened for 2 residents in a sample of 24 (residents #105 and #147) and 9 residents in a supplemental sample of 20 (residents #104, #109, #118, #124, #139, #143, #151, #152, and #153). The facility failed to ensure a multiple dose vial of insulin was discarded within 28 days upon being first opened in 2 of 2 medications rooms (East Unit and West Unit). This had the potential to affect 1 of 5 residents who received insulin (resident #F) in a sample of 24, and failed to ensure multiple dose vials of tuberculin (tuberculosis testing) were dated when opened, which had the potential to affect 146 residents who reside in the facility. Findings include: 1) During an observation of the East Unit Medication Room with the East Unit Manager on 03/08/11 at 11:05 a.m., there were 4 opened, partially filled, undated vials of tuberculin stored in the refrigerator. During an interview at the time of the observation, the East Unit Manager indicated she would discard the undated	F0425	**F425 PHARMACY SVC-ACCURATE PROCEDURES, RPH** The facility must provide routine and emergency drugs and biological to its residents, or obtain them under an agreement described in 483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This tag is being disputed. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice · There is no corrective action for residents since the	04/15/2011

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	vials of tuberculin. 2) During an observation of the West Unit, South Hall medication cart, with RN #9, there was an open vial of Novolog insulin labeled with resident #F's name. The vial indicated the insulin was opened on 01/20/11. During an interview at the time of the observation, RN #9 indicated the vial expired 30 days after the vial had been opened. Resident #F's record was reviewed on 03/08/11 at 10:30 a.m. The resident's diagnoses included, but was limited to, diabetes mellitus. The resident's Physician's Recapitulation Orders, dated 03/11, indicated the resident had an order, originally dated 10/19/10, for Novolog insulin, to be given on a sliding scale (insulin given by blood sugar results) three times a day. 3) During an observation of the West Unit Medication Room with RN #2 on 03/08/11 at 1 p.m., the following was observed in the medication refrigerator: A) There was a bottle of lansoprazole (stomach medication) suspension with an		alleged deficiency was in the past. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken · All residents have the potential to be effected by the alleged deficient practice. · Q.M.A.'s and nurses will be educated to ensure medications are dated when opened and discarded when expired and/or returned to the pharmacy upon non-use by the SDC/designee by 4/15/11. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur · Pharmacy technician will audit medication carts monthly. · Charge nurses will check expiration dated prior to medication administration. · The Unit Managers/designee will check medication carts for proper dating and discontinued/expired medications daily (Monday – Friday). How the corrective action(s) will be monitored to ensure the deficient	

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	expiration date of 03/05/11 for resident #105. Resident #105's record was reviewed on 03/08/11 at 1:05 p.m. The resident's diagnoses included, but were not limited to, cerebellar infarction and respiratory failure. The resident's Physician's Recapitulation Orders, dated 03/11, indicated an order for lansoprazole originally dated 08/17/10, to be given daily and to discard after 14 days. B) There was a bottle of omeprazole (stomach medication) liquid with an expiration date of 02/06/11 for resident #147. At the time of the observation, the West Unit Manager indicated the resident was deceased. Resident #147's closed record was reviewed on 03/09/11 at 11:10 a.m. The resident's diagnoses included, but were not limited to, kidney cancer with metastasis to the lung and hypertension. The resident's Physician's Recapitulation Orders, dated 03/11, indicated an order for omeprazole daily, originally ordered on 01/06/11.			

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	155166	A. BUILDING _____ B. WING _____	03/15/2011

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	The Nurses' Notes, dated 02/07/11 at 9:50 p.m., indicated the resident had passed away. C) There was a bottle of omeprazole liquid for resident #143, with an expiration date of 02/22/11. Resident #143's record was reviewed on 03/08/11 at 1:12 p.m. The resident's diagnoses included, but were not limited to convulsions and cerebral palsy. The resident's Physician's Recapitulation Orders, dated 03/11, indicated an order for omeprazole two times daily, originally dated on 07/26/11. D) There was an opened, undated vial of Humalog insulin for resident #118. Resident #118's record was reviewed on 03/08/11 at 1:10 p.m. The resident's diagnosis included, but was not limited to, diabetes mellitus. The resident's Physician's Recapitulation Orders, dated 03/11, indicated an order for Humalog insulin daily per sliding scale, originally dated on 07/12/08. E) There were two bottles of folic acid with expiration dates of 02/09/11 and			

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	02/16/11 for resident #109. Resident #109's record was reviewed on 03/08/11 at 1:15 p.m. The resident's diagnoses included, but were not limited to, pneumonia and congestive heart failure. The Physician's Recapitulation Orders, dated 02/11, indicated an order for Folic Acid daily, originally ordered on 10/22/10. F) There was a bottle of cephalexin (antibiotic) with an expiration date of 03/02/11 for resident #139. The resident's record was reviewed on 03/08/11 at 1:15 p.m. The resident's diagnoses included, but was not limited to, ineffective airway clearance related to paralysis. A Physician's Order, dated 02/16/11, indicated an order for cephalexin every 12 hours for 10 days for cellulitis. G) There was a bottle of famotidine (stomach medication) for resident #151 with an expiration date of 02/29/11. The resident's record was reviewed on 03/08/11 at 1:18 p.m. The resident's			

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	diagnoses included, but were not limited to, coronary artery disease and stroke. The resident's Physician's Recapitulation Orders, dated 03/11, indicated an order for famotidine every 12 hours, originally dated 09/11/10. H) There was a bottle of Baclofen (muscle relaxer) for resident #124 with an expiration date of 03/02/11. The resident's record was reviewed on 03/08/11 at 1:20 p.m. The resident's diagnosis included, but was not limited to, quadriplegia. The resident's Physician's Recapitulation Orders, dated 03/11, indicated an order for Baclofen every six hours, originally dated 12/31/10. I) There were four IV bags of Gentamycin (antibiotic) with expiration dates of 03/02/11, 03/04/11, and 03/07/11 for resident #152. The resident's record was reviewed on 03/08/11 at 1:22 p.m. The resident's diagnoses included, but were not limited to, respiratory failure and chronic kidney disease.			

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	A Physician's Order, dated 02/27/11 indicated an order to discontinue the IV Gentamycin. J) There were two IV bags of amikacin (antibiotic) with expiration dates of 02/15/11 for resident #153. The resident's record was reviewed on 03/08/11 at 1:25 p.m. The resident's diagnoses included, but were not limited to, pneumonia and respiratory failure. A Physician's Order, dated 02/10/11, indicated an order to discontinue the amikacin. K) There was an IV bag of Vancomycin (antibiotic) with an expiration date of 12/22/10 for resident #104. The resident's record was reviewed on 03/08/11 at 1:22 p.m. The resident's diagnoses included, but were not limited to, diabetes mellitus and ischemic heart disease. A Physician's Order, dated 12/2/10, indicated an order for Vancomycin every 36 hours for 14 days. L) There was one opened and undated vial of tuberculin.			

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During an interview at the time of the observation, the West Unit Manager indicated the nurses were supposed to check medication rooms for expired medications.

An undated facility policy, titled, "Storage and Maintenance of Medications", received from RN #2 as current on 03/08/11 at 2:55 p.m., indicated, "...Outdated refrigerator items must be removed from the refrigerator..."

Information obtained from the US Food and Drug Administration Web site on 03/11/11 at 4:45 p.m., indicated Novolog insulin vials could be stored up to 28 days after they were opened.

Information obtained from web site, "www.care.diabetesjournals.org", on 03/11/11 at 4:50 p.m., indicated the American Diabetes Association indicated, "...opened vials, whether or not refrigerated, must be used within 28 days. They must be discarded if not used within 28 days..."

3.1-25(o)

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F0441 SS=E	Based on observation, record review, and interview, the facility failed to pass ice water and beverages to residents in a manner to prevent the spread of infection in 1 of 4 dining rooms, which had the potential to affect 44 residents who received their meals in the main dining room and while passing fresh ice water on the East Unit, Front hall, which had the potential to affect 16 residents who reside on the front hall of the East Unit. Findings include: 1. During the lunch meal on 3/7/11 at 12:28 p.m., an ice scoop was observed sitting on top of the ice in an open plastic container. Activity Assistant #7 was observed to pick up the ice scoop out of the container and fill glasses with ice. The activity assistant placed the ice scoop back on top of the ice in the container. The activity assistant indicated they pass out beverages as the residents come into the dining room. On 3/7/11 at 12:30 p.m., Activity assistant #7 was observed to wipe off the top of the cart with a wet paper towel. The Activity Assistant then held the dirty, wet, paper towel over the ice container as she talked with Activity Assistant #8. Activity Assistants #7 and #8 then began filling glasses with the ice taking turns with the ice scoop and placing the scoop back on top of the ice in the container. The activity assistants continued to pass beverages to the residents in the main dining room. During an interview on 3/7/11 at 12:35 p.m., the	F0441	**F441 INFECTION CONTROL, PREVENT SPREAD, LINENS** The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** · There is no corrective action for residents since the alleged deficiency was in the past **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** · All residents have the potential to be effected by the alleged deficient practice. · All staff will be educated as to proper procedure for passing ice water by the SDC/designee by 4/15/11. · Ice scoop holders have been added to the hydration carts. A container with a lid will be used when passing ice water in the dining room. An ice scoop holder has been added to the cart.	04/15/2011

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	DoN (Director of Nursing) indicated "No, ladies get the ice scoop in a bag now. At 12:36 p.m., Activity Assistant #7 indicated the "ice scoop was in the ice when it came from the kitchen."		**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur** · The SDC/designee will observe ice water passing at least 3 times weekly for 4 weeks, then once weekly there after. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** · Observations will be documented on the “Passing Ice Water” skills validation tool weekly x 4, then monthly thereafter by the DNS/designee. · Data will be submitted to the CQI Committee for review and follow up. · Noncompliance with facility procedures may result in disciplinary action.	

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F0441 SS=E	2. During an observation on 03/08/11 at 3:05 p.m., LPN #10 was passing ice water to the resident's on the front hallway on the East Unit. LPN #10 was observed to bring an ice pitcher to the hallway from a resident's room, open up the ice chest, and used the ice scoop, which was being stored in the ice chest with the ice, and placed ice in the resident's water pitcher. LPN #10, then left the ice scoop in the ice chest and took the resident's pitcher back into the room. LPN #10 then went to the next resident's room and filled their ice pitchers with ice, using the scoop, which was stored in the ice chest. A facility policy, dated 02/10, titled, "Passing Fresh Ice Water", and received as current from RN #2, indicated, "...Replace the scoop in covered container, clean towel or plastic bag between rooms to prevent contamination..." 3.1-19(g)(1)	F0441	**F441 INFECTION CONTROL, PREVENT SPREAD, LINENS** The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** · There is no corrective action for residents since the alleged deficiency was in the past **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** · All residents have the potential to be effected by the alleged deficient practice. · All staff will be educated as to proper procedure for passing ice water by the SDC/designee by 4/15/11. · Ice scoop holders have been added to the hydration carts. A container with a lid will be used when passing ice water in the dining room. An ice scoop holder has been added to the cart.	04/15/2011

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			What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur · The SDC/designee will observe ice water passing at least 3 times weekly for 4 weeks, then once weekly there after. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** · Observations will be documented on the "Passing Ice Water" skills validation tool weekly x 4, then monthly thereafter by the DNS/designee. · Data will be submitted to the CQI Committee for review and follow up. · Noncompliance with facility procedures may result in disciplinary action.	

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F0514 SS=D	Based on record review and interview, the facility failed to ensure residents' records were complete and accurate related to physician's orders and resident status for 2 of 24 residents reviewed for medical records in a sample of 24. (residents #57 and #150) Findings include: 1. Resident #57's record was reviewed on 03/07/11 at 2:10 p.m. The residents diagnoses included, but were not limited to, hiatal hernia and dementia. A Physician's Order, dated 02/11/11, indicated an order for hospice to evaluate and treat the resident. A Social Service note, dated 02/11/11, indicated, "Message was left for Guardian...Requested (name) call NF (nursing facility) to enable res (resident) to enrolled in hospice care..." This was the last note in the resident's record about the hospice care. The resident's record lacked documentation to indicate the resident was receiving hospice. During an interview with Social Service #4 on 03/07/11 at 2:45 p.m., she indicated	F0514	**F514 Clinical Records** The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.The clinical record must contain sufficient information to identify the resident; a record of the resident' s assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** · There are not corrective actions for alleged deficient practices because they happened in the past. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** · Residents residing in the facility have the potential to be affected by the alleged deficient practice. · Physicians have been notified that they must sign all orders in the facility. No medical records are to be removed from the facility. · Social Services will be	04/15/2011

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	they could not get a response from the resident's Guardian. She indicated the Ombudsman had been notified and they were working with a lawyer to get another Guardian appointed for the resident. She indicated they had been communicating this information to the resident's physician. She indicated there had not been any further documentation in the resident's chart about the hospice or the Guardian status. 2. Resident #150's record was reviewed on 03/10/11 at 9 a.m. The resident's diagnoses included, but were not limited to, stroke and acute respiratory failure. The resident had been transferred and was deceased in the emergency room on 09/15/10. There were no physician's orders located in the resident's closed record. During an interview on 03/10/11 at 9:15 a.m., the Director of Nursing (DoN) indicated there were no physician's orders in the residents closed record. She indicated she would look for the physician's orders. During an interview on 03/10/11 at 12:10 p.m., the DoN indicated they could not find the resident's physician's orders. She		inserviced on timely documentation in the medical record by the DNS/designee by 4/15/11. · **The Medical Records Coordinator/designee will complete the Physician Services CQI tool three times a week for 4 weeks then weekly ongoing.** · **The DNS is responsible for compliance by reviewing the Physician Services CQI tool when completed.** How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place · Data will be submitted to the CQI Committee for review and follow up. Noncompliance with facility procedures may result in re-education and or disciplinary action.	

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	indicated they had found the transfer papers and there were a few physician's orders in there, but could not find the original or all of the other orders. During an interview on 03/10/11 at the daily conference at 3 p.m., the Administrator indicated they were looking at the resident's physician's orders. 3.1-50(a)(1) 3.1-50(a)(2)			